DAILEY PEDIATRICS + family medicine

Informed Consent

I, _____, hereby voluntary consent and provide permission for any type of examination, diagnostic testing, laboratory testing, immunizations, medication administration, evaluations, minor procedure, and treatment to be executed by the healthcare team at Dailey Pediatrics and Family Medicine. I understand that education will be provided about any of the above and questions will be answered prior to preceding with any form of treatment (which includes all of the above). I have the right to deny or decline any of the above services. By signing below, I understand that I have been educated on the above as it pertains to myself or as a legal representative for another party.

_____ _____

Patient Signature Date

_____ _____

Parent/Legal Representative Signature (if applicable) Date

HIPPA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Act of 1996, HIPPA, that as a patient I have certain rights to privacy regarding my protected health information, PHI. I understand that my PHI can and will be used for treatment, payment and health care operations. I have been offered and/or received a copy of the Privacy Notice which describes how my health information may be used or disclosed. I understand it is my responsibility to read carefully and ask any questions that I may have. The notice may change at any time. If PHI is needed in order to provide emergent treatment or transfer, permission is granted for the medical practice of Dailey Pediatrics and Family Medicine to use or disclose on my behalf to another healthcare provider or facility in an emergent situation. I have been educated that I also have the right to restrict the right to disclose my PHI. I understand that if I pay in full for services and treatments/items provided at the time of service/visit, I may restrict the disclosure of my PHI to a health plan for payment.

Date of Birth:_____

_____ _____

Print name Signature

Legal Representative for patient(please print)_____

Legal Representative for patient signature:_____

By signing below, I hereby authorize Dailey Pediatrics and Family Medicine to disclose my PHI with the following family members, friends, caretakers, or other representatives. I may revoke this authorization via writing at any time.

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____